Federal Regulations, Reporting Requirements and Statutes as Barriers to More Efficient Medicaid Program Operation: The State Perspective

Executive Summary

American Public Welfare Association

FEDERAL REGULATIONS, REPORTING REQUIREMENTS AND STATUTES AS BARRIERS TO MORE EFFICIENT MEDICAID PROGRAM OPERATION: THE STATE PERSPECTIVE

EXECUTIVE SUMMARY

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I. Overview

It has been said that because of its entitlement nature, Medicaid is uncontrollable. However, for state administrators, the Medicaid program is not open-ended in the short run. States must administer Medicaid within the limitations of federal requirements and a fixed amount of state funds; this requires considerable skill. Because of the rapid growth of all health care costs and the increasing size of state and federal Medicaid expenditures, much attention is focused on possible changes to the program.

For a number of years, Medicaid administrators have claimed that federal requirements have stood in the way of innovative approaches to the efficient delivery of health care services. There are several reasons for this. First, although statutes and regulations attempt to achieve specific policy objectives, they may create unintended and negative consequences. Second, even if requirements have the desired effect, policy objectives may change; or the circumstances that justified the requirements may change. Third, the volume of regulations

and requirements increases administrative complexity. And finally, the interrelationships between federal regulations and the particular delivery characteristics of each state program make it difficult to solve all problems through federal action. State administrators believe that Medicaid is a well-run program that has had considerable success providing health care services to the poor. States have developed many initiatives to reduce program costs without reducing covered services or the number of eligibles; these efforts have been well documented.* However, federal requirements do not always recognize state concerns and efforts to ensure the efficiency and fiscal integrity of program operations.

Clearly, it would be better to improve efficiency by restructuring the system of federal controls and requirements than to resort to extensive cutbacks. But changing federal policies to improve efficiency is no simple task, given the diversity of programs, the varying political and legal constraints, and the differences in staff and financial resources among states.

Workable policies demand a high level of state and federal

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* National Governors' Association, State Initiatives in Medicaid Cost Containment, 1980.

communication and understanding. In recent years such communication has been significant. State Medicaid administrators have been able to express concerns about policy issues to HCFA through the State Medicaid Directors' Association and the Health Care Committee of the National Council of Public Welfare Administrators.

This project developed from the continuing dialogue between state and federal administrators. Its main objective was to identify federal barriers to the effective and efficient operation of Medicaid, as perceived by state officials responsible for administering the program. A secondary objective was to quantify, to the extent possible, the impact of federal requirements on program operations and state costs.

The project was completed in three months. It was conducted in several phases:

- State Medicaid administrators were surveyed by telephone. They were asked to identify fifteen issues they think are barriers to efficient and effective operations, and to rank the issues in order of importance. They were also asked to provide any state reports or studies on the effect of regulations and other federal policies

on program operations and cost.

- A written survey was conducted. A list and description of forty-nine issues identified in the telephone survey were sent out, and states were asked to rank the major issues and indicate which ones were not a problem or a barrier.
- Because no reports or studies of costs of federal requirements were received as a result of the telephone survey, selected states were asked to develop cost estimates of the effects of certain Medicaid reforms on their programs.
- Preliminary findings were presented at the annual meeting of state Medicaid directors; additional findings were presented to an advisory group of state Medicaid directors. Their reactions and comments were incorporated in the report.

II. Summary of Major Issues

This section summarizes the major issues identified by states in the telephone and written surveys.

Free Choice. Requirements provide that recipients can obtain Medicaid services from any qualified provider. The "free choice" provision was established by Congress to guarantee that Medicaid patients would be treated in the mainstream of medicine. However, this provision has a cost: it limits states' ability to purchase quality services that may be available at relatively lower prices. States pointed out that many systems have been developed to ensure that quality care is available under Medicaid; and they contended that a provider's right to participate in the program irrespective of cost weakens a state's ability to negotiate payment rates. States place the highest priority on removal or modification of the free choice requirement, so that a Medicaid agency can act as a prudent buyer of services.

Hospital Reimbursement. States must pay the reasonable cost of inpatient hospital services. States can adopt the Medicare standards for determining reasonable cost, or they can develop an alternative system that must be

approved by the secretary of HHS. States believe the current system contains incentives for hospitals to continue to increase costs. In both the first and second surveys states ranked hospital reimbursement requirements as major barriers. States with approved alternatives felt frustrated because of the time and effort they had to spend to gain federal approval.

One major problem is that Medicaid has a relatively small share of the hospital market compared to Medicare; Medicare spends nearly four times as much per year on hospital care as does Medicaid. Given general increases in hospital expenditures caused by inflation, technology changes, and actions of all third-party payers, Medicaid can do little by itself to control hospital costs.

Nursing Home Reimbursement. The law requires states to reimburse nursing home services at rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care in conformity with state and federal laws, regulations, and standards. This requirement is new; the Omnibus Reconciliation Act of 1980 amended the previous requirement that nursing homes be reimbursed on the basis of reasonable cost.

Cost-related reimbursement contained little incentive for efficiency. Expenditures for nursing home services have accounted for almost half of Medicaid costs in recent years; also nursing home costs have increased more rapidly than other Medicaid costs. States now want the regulations that will implement the new law to give them the flexibility and authority Congress intended.

Physician Reimbursement. Medicaid requirements establish upper limits to payments to physicians, based on Medicare payments. In the telephone survey, half the states reported that these requirements are too inflexible; they also see the method's inherent inflationary incentive as a problem. Besides, they point out that the system is not adaptable to other state needs; for example, regional variations in Medicare rates within a state must be followed by the Medicaid agency, despite what may be strong needs to increase rates in certain areas to encourage provider participation. In addition, states are limited in their ability to grant fee increases for physicians who manage care for recipients, or to allow incentive payments for cost-effective practices.

Amount, Duration, and Scope/Comparability. Medicaid services available to any categorically needy individual must not be less in amount, duration, or scope than the services made available to any medically needy individual or to any other categorically needy individual, with certain exceptions. States cannot limit the amount, duration, and scope of services solely because of diagnosis, illness, or condition.

The intent of these requirements is to ensure that a basic level of services is available, and that there is no discrimination in the provision of services; but in practice, their effect has been to limit states' ability to make incremental and rational program changes. States cannot target services, or establish normative service standards on which payment can be based, even though such measures could be among the most effective and least harmful types of cutback.

Nor can states add limited services (such as certain services for the aged to defer or prevent institutionalization) or services based on diagnosis, such as health education or nutritional counseling. Not a single state felt these requirements were not a problem.

Mandatory and Optional Services. States must provide certain mandatory services, including:

- inpatient hospital services,
- outpatient hospital services,
- rural health clinic services,
- laboratory and X-ray services,
- skilled nursing facility services,
- family planning services,
- physician services, and
- nurse-midwife services.

States can choose to provide any optional services, such as drugs, dentures, eyeglasses, clinic services, intermediate care facility services, or other medical care recognized under state law.

States find that to categorize some services as mandatory and others as optional does not always make sense. For example, if it becomes necessary to eliminate a service, a state could drop drugs or ICF care; but nurse-midwife services could not be dropped. States also find they are limited in their ability to establish controls over mandatory services. States want greater freedom to define the array of available services.

Statewideness. A Medicaid State Plan must be in effect

in all political subdivisions of the states through a system of local offices. Statewideness requirements attempt to ensure that the level of local funding does not affect access to basic service, and that services are widely available. Statewideness leaves states without the flexibility to address problems unique to a given geographic area; the availability of services, and the needs of different groups, are not uniform in any state. In large state, disparities can be significant, especially between urban and rural areas. Under the present system, states cannot use one type of provider in one part of the state, and another type of provider in another part of the state, for essentially the same service. Statewideness requirements also prohibit a state from providing services to sub-state areas with special needs, such as areas with large concentrations of aged persons or refugees.

EPSDT. The Early and Periodic Screening Diagnosis and Treatment program was created by Congress to find and treat problems in poor children so that they would have a better chance of leading healthy and productive lives. Because states were slow to implement EPSDT, Congress established a penalty against federal funds for AFDC if a state does not meet certain requirements. After several attempts, HHS issued revised EPSDT penalty

regulations in 1979. States do not believe these regulations have been successful; on the contrary, they have had the effect of making it more costly and difficult for states to deliver health care to children.

In the telephone survey, more states identified EPSDT as a barrier than any other issue. Current EPSDT requirements seem not to consider other state health services that children may be receiving. The statutory penalty and the regulations may put the state at risk for attempting to serve certain difficult cases, so that avoiding the penalty, rather than serving children, has become the program focus. States would like to be able to deliver cost-effective services in EPSDT.

Utilization Control in Long-Term Care Facilities. The certification and review of long-term care services are governed by many requirements. These include physician certification, plan of care, admission review, inspections of care, and quarterly showing requirements. States would like to develop alternatives to the rigid timetables for the use of physicians and they would like to use physician assistants in underserved areas. States believe other utilization control functions can be done more efficiently by using sampling techniques and by

varying other time schedules, based on the performance of facilities and the needs of patients.

Co-Payments. The law allows states to share some of the cost of Medicaid with some recipients. However, no co-payment for mandatory services can be imposed on the categorically needy, and co-payment amounts must be nominal. Many states believe that the established maximum amounts for co-payments are too low. The prohibition against co-payments for mandatory services by the categorically needy prevents states from establishing systems to modify the inappropriate use of services, such as overuse of emergency rooms for routine problems. Because it is free, recipients may tend to make more use of a service than is necessary.

Professional Standards Review Organizations. PSRO's were established to promote the effective, efficient, and economical delivery of health care services by means of a peer review system. Studies by the Congressional Budget Office have shown that PSRO's may reduce Medicare costs somewhat, but that overall the program costs more than it saves. PSRO's have assumed utilization control functions formerly performed by state Medicaid programs. A number of states have reported increases in hospital

admissions, lengths of stay, and number of patient days in nursing homes since PSRO's began reviewing services. States believe that some PSRO's are not responsive to state needs and fiscal concerns.

Medicaid Quality Control. The quality control system is intended to reduce erroneous expenditures by monitoring:

- eligibility determinations,
- third-party liability activities, and
- claims processing.

States that do not meet target error rates are subject to a reduction in federal funds. In general, states believe that quality control efforts are important; but current requirements are based on the false assumption that state mismanagement is at the heart of program problems. Because quality control overstates the amount of funds that can be recovered, it reinforces the negative public image of Medicaid. States believe that the regression formula used to calculate error rates is inadequate, that quality control efforts are frequently trivial and not cost effective, and that the program has been used incorrectly to monitor state policies.

Eligibility Complexity. Medicaid eligibility policies are lengthy and complex. States must cover categorically needy recipients of cash assistance; states can choose to cover the medically needy, who do not have enough income for medical care. Certain groups have been given grandfathered eligibility when changes were made in Social Security or cash assistance programs; other eligibility extensions have been granted for retroactive and continued coverage.

Administrative responsibilities for determining Medicaid eligibility in a state may be shared by state AFDC and Medicaid eligibility staff, and by the Social Security Administration. Previous reports have found eligibility policies to be complex and unworkable. Efforts to reduce eligibility errors by stricter control of policy application may be somewhat misdirected; greater effort needs to be made to avoid errors by creating workable policies.

Health Maintenance Organization. HMO's provide specific comprehensive health care services to voluntarily enrolled members in return for a prepaid fixed payment. Many states have found HMO's to be an efficient alternative to the traditional fee-for-service system.

However, there are several barriers to more extensive use of HMO's in Medicaid; for example, Medicaid or Medicare patients cannot exceed 50 percent of the population served by an HMO. This can limit the use of HMO's in area with large concentrations of recipients.

Sterilization Requirements. Federal regulations about sterilizations are detailed and rigidly enforced. The intent of the federal policy is to ensure that sterilization services are received voluntarily, and that no one is sterilized without full knowledge or against one's will. States recognize the need to protect all citizens against abuse and believe that Medicaid recipients should be given the same protection as everyone else. Nevertheless, these goals do not justify the detail of existing regulations, which have negative effects: payments for necessary sterilization have been denied, program relationships with providers have been impaired, and administrative costs have increased.

III. Summary of Major Findings

States place high priority on relief from federal requirements. Both the response rate and the level of staff responding to the telephone survey were high. Forty-nine states and the District of Columbia participated in the telephone survey. Thirty-eight of the respondents were state Medicaid directors or commissioners of single state agencies. During the presentations of findings, many states expressed their support of the project's efforts to identify issues.

States believe that existing requirements contain many barriers to efficient operations. States identified a total of 556 separate issues in the telephone survey. These were classified into forty-nine issue areas; each area included at least two responses by states. These issue areas involve virtually all areas of Medicaid; a clear indication that problems are not narrowly focused. A number of issues were unique and did not fit into the classification scheme, but were nonetheless important; these may be issues special to a state, or emerging issues not yet identified by other states. The project did not attempt to follow up on these issues.

Many states noted that it was difficult to select only fifteen issues. In the telephone survey, five issues were identified by thirty or more states; twenty-four issues were identified by ten or more states. But problems are widespread; in their responses to the written survey, several states commented that they hoped all forty-nine issues would be pursued.

States have limited knowledge of the specific cost effects of federal requirements on program operations. Although requested to do so during the telephone survey, states did not send existing studies or reports with cost estimates of the effect of federal requirements. (Subsequently, some states were asked to develop cost estimates for certain reforms.) There may be several reasons for this lack of reports:

- States attempt to operate programs according to existing requirements. Studies of costs of those requirements are of low priority, because states feel they have little control over changing them.
- States may have information that is informal or in working documents, and they may have felt it was inappropriate to distribute such information.

The issues states ranked highest among barriers tended to be established by statute. These issues also tended to have major fiscal effects. They include requirements for free choice of provider; hospital reimbursement; co-payments; amount, duration, and scope; physician reimbursement; mandatory and optional services; statewideness; eligibility complexity; and the institutional bias of the program. Congressional action is necessary to resolve problems by granting more flexibility to states in these areas.

States perceive many administrative requirements as irritants that consume disproportionate amounts of staff time and attention. These issues include requirements for EPSDT, sterilizations, quality control, long-term care utilization, spenddown, state assessments and reviews, and notices of changes in methods or levels of reimbursement. These issues tend to be established by regulation; they do not tend to rank as high as issues with major fiscal effects.

Building the prudent-buyer concept into the Medicaid program is the most significant change that can be made to improve program efficiency. States believe the current system lacks incentives for economy. Statutes and

regulations such as those for free choice of providers; hospital, nursing home, and physician reimbursement; and co-payments block states from acting as prudent buyers. They have limited control over what services are bought, where they are bought, how they are bought, how much is paid, and in what manner payment is made. Recipients and providers are insulated from the consequences of the cost of using services, and demand is not moderated by market constraints.

Many existing requirements are unnecessarily detailed and process-oriented. Requirements that focus on processes can obscure the objectives of the program; resources are allocated to means rather than ends. Process orientation reduces the opportunity to develop innovations in individual state programs which other states can learn from and adapt to their own situations. Examples of process orientation include requirements for EPSDT, sterilizations, quality control, and notice of change in the method or level of reimbursement. Although process requirements by themselves may not seem substantial, their cumulative effect may be severe. For example, the many requirements that must be met before changes can be implemented hinder a state's ability to make needed changes promptly.

For any change, a state may have to meet with its Medical Care Advisory Committee, publish notice of a change in reimbursement levels sixty days before it can be implemented, and obtain approval of State Plan changes from the HCFA regional office. All this is in addition to such matters as obtaining legislative approval, making computer programming changes, training staff, informing the public, and publishing manuals and instructions.

States believe that federal oversight of and intervention in state operations need improvement. States took issue with the sheer weight of federal involvement in the program; in particular, they questioned the duplication and the lack of coordination among the many federal reviews. Reviews include state assessments, quality control reviews, MMIS certification and system performance reviews, and validation reviews. Reviews are time-consuming for state officials, but rarely produce useful results. States believe that there is a lack of federal understanding of state program operations, and that practical and knowledgeable technical assistance is not available.

States feel limited in ability to target services according to need or to move to a new mix of services. Existing requirements for amount, duration, and scope, mandatory

and optional services, and statewideness establish a basic level of Medicaid service availability throughout the state, and prohibit any discrimination against localities, population groups, or people with specific problems. In principle, these guarantees are important; they recognize the national commitment to access to a basic level of health care. In practice, they have limited states' abilities to adjust to changing situations and different needs, because minimum standards have become absolute limits.

States believe that the actions of other federal health programs have major effects on Medicaid and limit state control of the program. The foremost influence is Medicare, which affects Medicaid because of the relative share of expenditures by each program, and because specific limits to Medicaid reimbursement are established according to Medicare. There are also many areas of policy coordination and data exchange between the programs. States are limited in utilization control activities, because PSRO's have assumed functions that were formerly performed by states. A number of states reported major losses of program control and increased expenditures because of PSRO activities.

The institutional bias of the program continues to trouble states. Medicaid long-term care means

primarily institutional care; many institutional admissions are not necessary but are encouraged by existing policies. Major factors causing institutional bias include certain eligibility requirements, the lack of community and home care alternatives, and limited assessment and placement mechanisms for avoiding institutionalization.

States want prompt action on efforts to grant more flexibility. This project did not directly address proposals for block grants or a cap on Medicaid expenditures. However, these proposals affected the discussion of findings of this project. States want to be assured that flexibility will be available so they can reduce the negative effects of expected cutbacks in federal funds.

IV. Recommendations and Conclusions

Although this study was broad and covered statutes, regulations, and reporting requirements, it had certain limitations. First, the project was conducted in a very short time--less than three months--so that results could be presented at the annual meeting of state Medicaid directors. Primary data were gathered by telephone, a method which carries some risk of error. Although project staff contacted all states with Medicaid programs, there was no attempt to study individual programs in depth, or to focus on states with larger shares of the Medicaid budget.

Second, as the study began, the Reagan administration announced its proposal to cap Medicaid expenditures. This study does not examine the political constraints on solutions to problems, or what input and effect the provider community will have on possible program changes.

Third, this project--because its objective was to identify problems--does not focus on federal requirements the states consider to be good because they moderate provider or consumer demands. Nor does the project highlight successes in the federal and state Medicaid partnership.

The major objective of this study was to identify federal regulations, statutes, and reporting requirements state Medicaid administrators perceive as barriers to efficient Medicaid operation.

The issues ranked highest by states tended to be based on statute, and will require congressional action before states can make changes. However, HCFA can initiate some regulatory changes promptly, and thereby demonstrate its commitment to removing or changing unnecessary federal requirements:

- EPSDT regulations should be repealed and replaced by the action planning approach suggested by the EPSDT Technical Advisory Group.

- Sterilization regulations should be repealed and replaced by state requirements that protect against abuses.

- Requirements to publish notice of changes in the level or method of reimbursement should be repealed.

- Nursing home reimbursement regulations will need to be changed because of recent changes in the law. The new regulations should be written to allow states the flexibility intended by Congress.

- The reclassification of nursing homes as institutions for mental disease should be stopped.

- Requirements for Medical Care Advisory Committees should be repealed.

Priority areas for joint state and federal efforts to remove regulatory and administrative barriers should be:

- quality control
- eligibility issues (especially spenddown)
- state assessments and reviews
- ICF-MR requirements.

Existing Technical Advisory Groups (TAG's) can be used to develop policy alternatives for quality control and eligibility. Creating additional Technical Advisory Groups and allocating more resources to accelerate the schedules of all TAG's can produce the necessary results.

Federal requirements can be improved by developing more active advance consultation about decisions to regulate, alternatives to regulations, and the costs of requirements. TAG's may be one forum for such consultation.

Little is known about the exact costs of requirement-created problems. States may need to allocate more resources to cost analysis, if they are to argue more effectively for specific changes in federal requirements. HCFA, too, needs to allocate sufficient resources to cost and policy analyses of regulations, to hasten the repeal of unnecessary requirements and to ensure that future requirements are as effective as possible.

State administrators do not perceive much flexibility in existing requirements; that perception affects state management of the program. Even if that perception is inaccurate, there is at the very least a strong need to improve technical assistance given to states. Technical assistance is critical as resources shrink, because program innovations that improve efficiency and reduce costs must be vigorously supported.

Given the number and diversity of state programs, it is not surprising that specific national solutions to problems are not always apparent. Indeed, if they were, it would be far easier to solve problems through federal regulations. States consistently stressed the desire for flexibility, so that they can take innovative and varied approaches to Medicaid administration; obviously, not all states will use flexibility the same way.

As for HCFA, it now needs to rethink its efforts to support state management activities, and it needs to decide how mutual state and federal objectives can be reached. The broad challenge is to seek national solutions to problems in delivering quality health care services under Medicaid in many diverse--but related--state initiatives and activities.

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